

907 KAR 7:010. Home and community based waiver services version 2.

RELATES TO: KRS 205.520(3), 205.5605, 205.5606, 205.5607, 205.635, 42 C.F.R. 440.180
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.5606, 42 C.F.R.

440.180, 42 U.S.C. 1396a, 1396b, 1396d, 1396n

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the coverage provisions and requirements for home and community based waiver services version 2.

Section 1. Definitions. (1) "1915(c) home and community based services waiver program" means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(2) "Abuse" regarding:

(a) An adult is defined by KRS 209.020(8); or

(b) A child means abuse pursuant to KRS Chapter 600 or 620.

(3) "ADHC" means adult day health care.

(4) "ADHC center" means an adult day health care center licensed in accordance with 902 KAR 20:066.

(5) "ADHC services" means health-related services provided on a regularly-scheduled basis that ensure optimal functioning of a participant who:

(a) Does not require twenty-four (24) hour care in an institutional setting; and

(b) May need twenty-four (24) hour respite services when experiencing a short-term crisis due to the temporary or permanent loss of the primary caregiver.

(6) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(7) "Area agency on aging and independent living" means:

(a) An area agency on living as defined by 42 U.S.C. 3002(6); and

(b) A local agency designated by the Department for Aging and Independent Living to administer funds received under Title III for a given planning and service area.

(8) "Assessment" means an evaluation completed using the Kentucky Home Assessment Tool (K-HAT).

(9) "Blended services" means a non-duplicative combination of HCB waiver services that are not participant-directed services as well as participant-directed services.

(10) "Center for independent living" is defined by 42 U.S.C. 796a(1).

(11) "Certified nutritionist" is defined by KRS 310.005(12).

(12) "Certified social worker" means an individual who meets the requirements established in KRS 335.080.

(13) "Chemical restraint" means a drug or medication:

(a) Used to restrict an individual's:

1. Behavior; or

2. Freedom of movement; and

(b) 1. That is not a standard treatment for the individual's condition; or

2. Dosage that is not an appropriate dosage for the individual's condition.

(14) "Communicable disease" means a disease that is transmitted:

(a) Through direct contact with an infected individual;

(b) Indirectly through an organism that carries disease-causing microorganisms from one (1) host to another or a bacteriophage, a plasmid, or another agent that transfers genetic material

from one (1) location to another; or

(c) Indirectly by a bacteriophage, a plasmid, or another agent that transfers genetic material from one (1) location to another.

(15) "DAIL" means the Department for Aging and Independent Living.

(16) "DCBS" means the Department for Community Based Services.

(17) "Department" means the Department for Medicaid Services or its designee.

(18) "Electronic signature" is defined by KRS 369.102(8).

(19) "Experimental goods or services" means goods or services that are serving the ends of or used as a means of experimentation.

(20) "Exploitation" regarding:

(a) An adult is defined by KRS 209.020(9); or

(b) A child means exploitation pursuant to KRS Chapter 600 or 620.

(21) "Home and community based waiver services" or "HCB waiver services" means home and community based waiver services:

(a) Covered by the department pursuant to this administrative regulation; and

(b) For individuals who meet the requirements of Section 4 of this administrative regulation.

(22) "Home and community support services" means nonresidential and nonmedical home and community based services and supports that:

(a) Meet the participant's needs; and

(b) Constitute a cost-effective use of funds.

(23) "Home delivered meal provider" means a food service establishment as defined by KRS 217.015(21).

(24) "Home health agency" means an agency that is:

(a) Licensed in accordance with 902 KAR 20:081; and

(b) Medicare and Medicaid certified.

(25) "Illicit drug" means:

(a) A drug, prescription or not prescription, used illegally or in excess of therapeutic levels; or

(b) A prohibited drug.

(26) "Immediate family member" is defined by KRS 205.8451(3).

(27) "Informed choice" means a choice among options based on accurate and thorough knowledge and understanding to the participant regarding:

(a) The services and supports to be received; and

(b) From whom services and supports will be received.

(28) "Legally responsible individual" means an individual who:

(a) Has a duty under state law to care for another person; and

(b) 1. Is a parent (biological, adoptive, or foster) of a minor child and provides care to the child;

2. Is the guardian of a minor child and provides care to the child; or

3. Is a spouse of a participant.

(29) "Licensed clinical social worker" means an individual who meets the requirements established by KRS 335.100.

(30) "Licensed dietitian" is defined by KRS 310.005(11).

(31) "Licensed medical professional" means:

(a) A physician;

(b) An advanced practice registered nurse;

(c) A physician assistant;

(d) A registered nurse;

(e) A licensed practical nurse; or

(f) A pharmacist.

(32) "Licensed practical nurse" or "LPN" means a person who:

- (a) Meets the definition established by KRS 314.011(9); and
- (b) Works under the supervision of a registered nurse.
- (33) "Licensed social worker" means an individual who meets the requirements established by KRS 335.090.
- (34) "MWMA" means the Kentucky Medicaid Waiver Management Application internet portal located at <http://chfs.ky.gov/dms/mwma.htm>.
- (35) "Natural supports" means a non-paid person, persons, primary caregiver, or community resource who can provide or has historically provided assistance to the participant or due to the familial relationship would be expected to provide assistance.
- (36) "Neglect" regarding:
 - (a) An adult is defined by KRS 209.020(016); or
 - (b) A child means neglect pursuant to KRS Chapter 600 or 620.
- (37) "NF" means nursing facility.
- (38) "NF level of care" means a high intensity or low intensity patient status determination made by the department in accordance with 907 KAR 1:022.
- (39) "Normal baby-sitting" means general care provided to a child that includes custody, control, and supervision.
- (40) "Normal care sitting" means general care:
 - (a) Provided to an adult who is at least eighteen (18) years of age; and
 - (b) That includes custody, control, and supervision.
- (41) "Participant" means a recipient who meets the:
 - (a) NF level of care criteria established in 907 KAR 1:022; and
 - (b) Eligibility criteria for HCB waiver services established in Section 4 of this administrative regulation.
- (42) "Participant corrective action plan" means a written plan that is developed by the case manager or service advisor in conjunction with the participant or representative to identify, eliminate, and prevent future violations from occurring by:
 - (a) Providing the participant or representative with the specific administrative regulation that has been violated;
 - (b) Identifying factual information regarding the violation; and
 - (c) Reaching an agreement between the case manager and the participant or representative to the resolution and being in compliance within the timeframe established in the participant corrective action plan being issued.
- (43) "PDS" means participant-directed services.
- (44) "Person-centered service plan" means a written individualized plan of services for a participant that meets the requirements established in Section 7 of this administrative regulation.
- (45) "Person-centered team" means a participant, the participant's guardian or representative, and other individuals who are natural or paid supports and who:
 - (a) Recognize that evidenced based decisions are determined within the basic framework of what is important for the participant and within the context of what is important to the participant based on informed choice;
 - (b) Work together to identify what roles they will assume to assist the participant in becoming as independent as possible in meeting the participant's needs; and
 - (c) Include providers who receive payment for services and who shall:
 - 1. Be active contributing members of the person-centered team meetings;
 - 2. Base their input upon evidence-based information; and
 - 3. Not request reimbursement for person-centered team meetings.
- (46) "Physical restraint" means any manual method or physical or mechanical device, material, or equipment that:

(a) Immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely; and

(b) Does not include:

1. Orthopedically prescribed devices or other devices, surgical dressings or bandages, or protective helmets; or

2. Other methods that involve the physical holding of a person for the purpose of:

a. Conducting routine physical examinations or tests;

b. Protecting the person from falling out of bed; or

c. Permitting the person to participate in activities without the risk of physical harm.

(47) "Physician assistant" or "PA" is defined by KRS 311.840(3).

(48) "Plan of treatment" means a care plan developed and used by an ADHC center based on the participant's individualized ADHC service needs, goals, interventions, and outcomes.

(49) "Prohibited drug" means a drug or substance that is illegal under KRS Chapter 218A.

(50) "Public health department" means an agency recognized by the Department for Public Health pursuant to 902 KAR Chapter 8.

(51) "Recipient" is defined by KRS 205.8451(9).

(52) "Registered nurse" or "RN" means a person who:

(a) Meets the definition established by KRS 314.011(5); and

(b) Has one (1) year or more experience as a professional nurse.

(53) "Representative" is defined by KRS 205.5605(6).

(54) "Service advisor" is defined by KRS 205.5605(7).

(55) "Sex crime" is defined by KRS 17.165(1).

(56) "Violent crime" is defined by KRS 17.165(3).

(57) "Violent offender" is defined by KRS 17.165(2).

Section 2. Provider Participation Requirements Excluding Participant-Directed Services. (1) In order to provide HCB waiver services version 2, excluding participant-directed services, an HCB waiver provider shall:

(a) Be:

1. Approved by the department, licensed, or certified; and

2.a. An adult day health care center;

b. A home health agency;

c. A center for independent living;

d. A public health department;

e. A home delivered meal provider; or

f. An area agency on aging and independent living; and

(b) Meet the service requirements specified in Section 5 of this administrative regulation for any service provided by the provider.

(2) An out-of-state HCB waiver provider shall comply with the requirements of this administrative regulation.

(3) An HCB waiver provider:

(a) Shall comply with:

1. 907 KAR 1:671;

2. 907 KAR 1:672;

3. 907 KAR 1:673;

4. 907 KAR 7:005 if the provider is a certified waiver provider;

5. 902 KAR 20:081 if the provider is a home health agency; and

6. This administrative regulation;

(b) Shall not enroll a participant for whom the provider cannot provide HCB waiver services;

- (c) Shall choose to accept or not accept a participant;
- (d) 1. Shall implement a procedure to ensure that critical incident reporting is done in accordance with Section 9 of this administrative regulation;
- 2. Shall implement a process for communicating the critical incident, the critical incident outcome, and the critical incident prevention plan to the participant, a family member of the participant, or participant's guardian or legal representative; and
- 3. Shall maintain documentation of any communication provided in accordance with subparagraph 2 of this paragraph by:
 - a. Entering a record of the communication in the:
 - (i) MWMA; and
 - (ii) Participant's case record; and
 - b. Having the documentation signed and dated by the staff member making the entry;
 - (e) Shall inform a participant or any interested party in writing of the provider's:
 - 1. Hours of operation; and
 - 2. Policies and procedures;
 - (f) Shall not permit a staff member who has contracted a communicable disease to provide a service to a participant until the condition is determined to no longer be contagious;
 - (g) Shall ensure that a staff supervisor is available at all times to provide oversight and technical assistance;
 - (h) Shall ensure that each staff person:
 - 1. Prior to independently providing a direct service, is trained regarding:
 - a. Abuse, neglect, fraud, and exploitation;
 - b. The reporting of abuse, neglect, fraud, and exploitation;
 - c. Person-centered planning principles;
 - d. Documentation requirements; and
 - e. HCB services definitions and requirements;
 - 2. Receives DAIL attendant care certification training initially and then annually thereafter;
 - 3. Receives cardio pulmonary resuscitation certification and first aid certification provided by a nationally accredited entity within six (6) months of employment;
 - 4. Maintains current CPR certification and first aid certification for the duration of the staff person's employment;
 - 5.a. Completes a tuberculosis (TB) risk assessment performed by a licensed medical professional within the past twelve (12) months and annually thereafter; and
 - b.(i) If a TB risk assessment resulted in a TB skin test being performed, have a negative result within the past twelve (12) months as documented on test results received by the provider within thirty (30) days of the date of hire; and
 - (ii) If it is determined that signs or symptoms of active disease are present, in order for the person to be allowed to work, be administered follow-up testing by his or her physician or physician assistant with the testing indicating the person does not have active TB disease; and
 - 6. Prior to the beginning of employment, has successfully passed a drug test with no indication of prohibited or illicit drug use;
 - (i) Shall maintain documentation:
 - 1.a. Of an annual TB risk assessment or negative TB test for each staff who provides services or supervision; or
 - b. Annually for each staff with a positive TB test that ensures no active disease symptoms are present; and
 - 2. Of the results of a drug test for each staff;
 - (j) 1. Shall:
 - a. Prior to hiring an individual, obtain:

(i) The results of a criminal record check from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment;

(ii) The results of a Nurse Aide Abuse Registry check as described in 906 KAR 1:100 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; and

(iii) The results of a Caregiver Misconduct Registry check as described in 922 KAR 5:120 and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; and

b. Within thirty (30) days of the date of hire, obtain the results of a Central Registry check as described in 922 KAR 1:470 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; or

2. May use Kentucky's national background check program established by 906 KAR 1:190 to satisfy the background check requirements of subparagraph 1 of this paragraph; and

(k) Shall not allow a staff person to provide HCB waiver services if the individual:

1. Has a prior conviction of or pled guilty to a:

a. Sex crime; or

b. Violent crime;

2. Is a violent offender;

3. Has a prior felony conviction;

4. Has a drug related conviction, felony plea bargain, or amended plea bargain conviction within the past five (5) years;

5. Has a positive drug test for an illicit or a prohibited drug;

6. Has a conviction of abuse, neglect, or exploitation;

7. Has a Cabinet for Health and Family Services finding of:

a. Child abuse or neglect pursuant to the Central Registry as described in 922 KAR 1:470; or

b. Adult abuse, neglect, or exploitation pursuant to the Caregiver Misconduct

Registry as described in 922 KAR 5:120;

8. Is listed on the Nurse Aide Abuse Registry pursuant to 906 KAR 1:100;

9. Within twelve (12) months prior to employment, is listed on or has a finding indicated on another state's equivalent of the:

a. Nurse Aide Abuse Registry as described in 906 KAR 1:100 if the other state has an equivalent;

b. Caregiver Misconduct Registry as described in 922 KAR 5:120 if the other state has an equivalent; or

c. Central Registry as described in 922 KAR 1:470 if the other state has an equivalent; or

10. Has been convicted of Medicaid or Medicare fraud.

(4) A home delivered meal provider shall:

(a) Comply with KRS Chapter 217 and 902 KAR 45:005 requirements regarding food and food service establishments; and

(b) Be subject to:

1. Monitoring; and

2. Annual certification by DAIL in accordance with 907 KAR 7:005.

Section 3. Maintenance of Records. (1)(a) Regarding each participant, an HCB waiver provider shall maintain:

1. A case record;

2. Fiscal reports and service records regarding services provided; and

3. Critical incident reports.

- (b) A case record shall:
1. Be maintained in the MWMA; and
 2. Contain:
 - a. A comprehensive assessment approved by the department;
 - b. A completed person-centered service plan;
 - c. A copy of the MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form signed by the participant or participant's legal representative at the time of application or reapplication and each recertification thereafter;
 - d. The name of the:
 - (i) Case manager or service advisor; and
 - (ii) Independent assessor;
 - e. Documentation of all level of care determinations;
 - f. Documentation related to prior authorizations including requests, approvals, and denials;
 - g. Documentation of each contact with, or on behalf of, the participant;
 - h. Documentation that the participant, if receiving ADHC services, was provided a copy of the ADHC center's posted hours of operation;
 - i. Documentation that the participant or participant's legal representative was informed of the procedure for reporting complaints and critical incidents; and
 - j. Documentation of each service provided, which shall include:
 - (i) The date the service was provided;
 - (ii) The duration of the service;
 - (iii) The arrival and departure time of the provider, excluding travel time, if the service was provided at the participant's home;
 - (iv) Itemization of each service delivered;
 - (v) The participant's arrival and departure time, excluding travel time, if the service was provided at the ADHC center;
 - (vi) A monthly progress note each month, which shall include documentation of changes, responses, and services utilized to evaluate the participant's health, safety, and welfare needs; and
 - (vii) The signature of the service provider.
 - (c)1. Fiscal reports regarding services provided, service records regarding services provided, and critical incident reports shall be retained:
 - a. At least six (6) years from the date that a covered service is provided unless the participant is a minor; or
 - b. If the participant is a minor, the longer of:
 - (i) Three (3) years after the participant reaches the age of majority under state law; or
 - (ii) Six (6) years from the date that a covered service is provided.
 2. If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in subparagraph 1. of this paragraph, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.
 - (2) Upon request, an HCB provider shall make information regarding service and financial records available to the:
 - (a) Department;
 - (b) Cabinet for Health and Family Services, Office of Inspector General or its designee;
 - (c) DAIL;
 - (d) The United States Department for Health and Human Services or its designee;
 - (e) General Accounting Office or its designee;
 - (f) Office of the Auditor of Public Accounts or its designee; or
 - (g) Office of the Attorney General or its designee.

Section 4. Participant Eligibility Determinations and Redeterminations. (1)(a) To be eligible to receive HCB waiver services, an individual:

1. Shall be determined by the department to meet NF level of care requirements;
2. Without waiver services may be admitted by a physician's order to an NF;
3. Shall be screened by the department for the purpose of making a preliminary determination of whether the individual might qualify for HCB waiver services; and
4. Shall meet the Medicaid eligibility requirements established in 907 KAR 20:010.

(b) In addition to the individual meeting the requirements established in paragraph (a) of this subsection, the individual, a representative on behalf of the individual, or independent assessor shall:

1. Apply for 1915(c) home and community based waiver services via the MWMA; and
2. Complete and upload into the MWMA a:
 - a. MAP - 115 Application Intake - Participant Authorization; and
 - b. MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form.

(c) A participant, participant's guardian, or participant's legal representative shall annually sign a MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form at the time of each recertification to document that the participant was informed of the choice to receive HCB waiver or institutional services.

(2) The department shall perform a level of care determination for each participant:

- (a) At least once every twelve (12) months; and
- (b) More often if there is a change in function or condition.

(3) An HCB waiver service shall not be provided to a participant who:

(a) Does not require a service other than:

1. An environmental or minor home adaptation;
2. A home delivered meal;
3. Conflict free case management; or
4. Goods and services;

(b) Is an inpatient of:

1. A hospital;
2. An NF; or
3. An intermediate care facility for individuals with an intellectual disability;

(c) Is a resident of a licensed personal care home;

(d) Has a primary diagnosis that is not related to age or a disability; or

(e) Is receiving services from another Medicaid 1915(c) home and community based services waiver program.

(4) An eligible participant or the participant's legal representative shall select a participating HCB waiver provider from which the participant wishes to receive HCB waiver services.

(5) An HCB waiver provider shall notify in writing electronically or in print the local DCBS office and the department of a participant's:

(a) Termination from the HCB waiver program;

(b)1. Admission to an NF for less than sixty (60) consecutive days; and

2. Return to the HCB waiver program from an NF within sixty (60) consecutive days; or

(c) Failure to access services within the parameters of the participant's level of care determination for greater than sixty (60) days.

Section 5. Covered Services and Related Requirements. (1)(a) HCB waiver services shall include:

1. Conflict free case management;

2. Attendant care;
3. Specialized respite care services;
4. Environmental or minor home adaptations;
5. ADHC services;
6. Goods and services; or
7. Home delivered meals.

(b)1. Participant-directed services shall include:

- a. Environmental or minor home adaptations;
- b. Goods and services;
- c. Home and community supports;
- d. Non-specialized respite care services; or
- e. PDS coordination services.

2. Participant-directed services provided to a participant shall not replace the participant's natural support system.

(2)(a) An HCB waiver service and a PDS, except as established in subparagraph 3 of this paragraph, shall:

1. Be prior authorized by the department based upon a request that provides all of the information needed to ensure that the service or modification of the service meets the needs of the participant;

2. Be provided pursuant to the participant's person-centered service plan;

3. Except for PDS, not be provided by an immediate family member, guardian, or legally responsible individual of the participant;

4. Be accessed within sixty (60) days of the date of prior authorization;

5. Be a one (1) on one (1) encounter except for:

a. An ADHC service in which case the ADHC center providing the service shall comply with the ADHC personnel requirements established in 902 KAR 20:066; or

b. A service for which a one (1) on one (1) encounter is not appropriate due to the participant's circumstances or condition in which case the circumstances or condition shall be documented in the:

(i) Assessment; and

(ii) Person-centered service plan;

6. Not occur at the same time as another service, regardless of payer source, except for a:

a. Doctor visit; or

b. Physical therapy, occupational therapy, or speech-language pathology service appointment; and

7. Be provided by an individual who:

a. Does not have a communicable disease pursuant to Section 2(3)(f) of this administrative regulation; and

b. Provides services at a level that appropriately and safely meets the needs of the participant.

(b) A 1915(c) home and community based waiver service that is not part of a hospice service package may be covered in conjunction with hospice services.

(3) To request prior authorization:

(a) For a non-PDS HCB waiver service, a case manager shall submit a completed person-centered service plan to the department; or

(b) For a PDS, a service advisor shall submit a completed person-centered service plan to the department.

(4) Except for case management and PDS coordination, services shall not begin and payment shall not be made for services until:

(a) A level of care determination has been approved by the department;

(b) A person-centered service plan has been:

1. Developed by the person-centered team; and
2. Approved by the department; and

(c)1. DCBS has determined that the individual meets financial eligibility requirements and valid documentation of eligibility is on file for a new applicant for Medicaid; or

2. The first day of the month following the level of care determination if the applicant is a recipient currently enrolled with a managed care organization. The managed care organization shall be responsible for ensuring the applicant's health, safety, and welfare during the period between the level of care determination and the first day of the month following the level of care determination.

(5)(a) Case management requirements shall be as established in Section 8 of this administrative regulation.

(b) Except for the requirement established in Section 8(7)(b), the requirements established in Sections 6 and 8 of this administrative regulation shall apply to service advisors.

(6)(a) An attendant care service shall provide care that consists of:

1. General household activities including:
 - a. Cleaning;
 - b. Cooking; or
 - c. Chores;
2. Personal care services including assistance with:

- a. Bathing;
- b. Grooming;
- c. Dressing;
- d. Eating;
- e. Toileting;
- f. Transferring;
- g. Assistance with self-administration of medication; or
- h. Ambulation; or

3. Transporting a participant to a needed place as specified in the participant's person-centered service plan including:

- a. A grocery;
- b. A pharmacy; or
- c. An appointment.

(b)1. An individual transporting a participant shall have a valid driver's license.

2. A minimum of current liability insurance shall be required for a vehicle used to transport a participant.

(c)1. An attendant care provider shall maintain a sign in and out log documenting the provision of services to participants.

2. Documentation shall include:

- a. The date the service was provided;
- b. The duration of the service;
- c. The arrival and departure time of the provider;
- d. A description of the service provided; and
- e. The name, title, and signature of the staff who provided the service.

(7)(a) A specialized respite care service shall:

1. Be short-term care based on the absence or need for relief of the non-paid primary caregiver;

2. Be provided by staff who provides services at a level that appropriately and safely meets the needs of the participant;

3. Be provided to a participant who has care needs beyond normal baby-sitting or normal care

sitting;

4. If the participant receiving the service is assessed pursuant to 907 KAR 7:015 as qualifying the provider for Level II reimbursement, have twenty-four (24) hour access to an RN for emergency situations and consultations; and

5. If applicable, be provided in accordance with 902 KAR 20:066.

(b)1. A provider of specialized respite care shall maintain a sign in and out log documenting the provision of services to participants.

2. Documentation shall include:

- a. The date the service was provided;
- b. The duration of the service;
- c. The arrival and departure time of the provider;
- d. A description of the service provided; and
- e. The name, title, and signature of the staff who provided the service.

(8)(a) An environmental or minor home adaptation service shall:

1. Be a physical adaptation to a home owned by the participant or family member of the participant that is necessary to ensure the health, welfare, and safety of the participant;
2. Meet all applicable safety and local building codes;
3. Relate strictly to the participant's disability and needs;
4. Exclude an adaptation or improvement to a home that has no direct medical or remedial benefit to the participant;
5. Be provided by a licensed and insured provider qualified to provide the modification;
6. Not add to the total square footage of a home except if necessary to complete an adaptation;
7. Be submitted on the person-centered service plan for prior authorization; and
8. Not be covered unless prior authorized.

(b) A personal emergency response system shall be considered a covered environmental or minor home adaptation if it meets the requirements established in this subsection.

(9)(a) An ADHC service shall:

1. Be provided to a participant who is at least twenty-one (21) years of age;
2. Include the following basic services and necessities provided to participants during the posted hours of operation:
 - a. Skilled nursing services provided by an RN or LPN, including ostomy care, urinary catheter care, decubitus care, tube feeding, venipuncture, insulin injections, tracheotomy care, or medical monitoring;
 - b. Meal service corresponding with hours of operation with a minimum of one (1) meal per day and therapeutic diets as required;
 - c. Snacks;
 - d. The presence of an RN or LPN;
 - e. Age and diagnosis appropriate daily activities; and
 - f. Routine services that meet the daily personal and health care needs of a participant, including:
 - (i) Monitoring of vital signs;
 - (ii) Assistance with activities of daily living; and
 - (iii) Monitoring and supervision of self-administered medications, therapeutic programs, and incidental supplies and equipment needed for use by a participant;
3. Include developing, implementing, and maintaining nursing policies for nursing or medical procedures performed in the ADHC center;
4. Include specialized respite care services pursuant to subsection (7) of this section;
5. Be provided to a participant by the health team in an ADHC center, which may include:
 - a. A physician;

- b. A physician assistant;
 - c. An APRN;
 - d. An RN;
 - e. An LPN;
 - f. An activities director;
 - g. A licensed social worker;
 - h. A certified social worker;
 - i. A licensed clinical social worker;
 - j. A certified nutritionist; or
 - k. A health aide; and
6. Be provided pursuant to a plan of treatment that is included in the participant's person-centered service plan.
- (b) A plan of treatment shall:
- 1. Be developed and signed by each member of the plan of treatment team, which shall include the participant, participant's guardian, or participant's legal representative;
 - 2. Include:
 - a. Pertinent diagnoses;
 - b. Mental status;
 - c. Services required;
 - d. Medication or food allergies and special diet;
 - e. Contradictions for specific types of activities and preventive health care measures;
 - f. Frequency of visits to the ADHC center;
 - g. Prognosis;
 - h. Rehabilitation potential;
 - i. Functional limitation;
 - j. Activities permitted;
 - k. Nutritional requirements;
 - l. Medication;
 - m. Treatment;
 - n. Safety measures to protect against injury;
 - o. Instructions for timely discharge; and
 - p. Other pertinent information; and
 - 3. Be developed annually from information on the assessment and revised as needed.
- (c)1. Modification of an ADHC unit of service shall require:
- a. Modification of the participant's person-centered service plan; and
 - b. Prior authorization.
2. Upon approval or denial of a prior authorization request, the department shall provide written notification to the case manager and to the participant.
3. A case manager shall:
- a. Inform the ADHC center of approval or denial; and
 - b. Document the approval or denial in the case record.
- (d)1. An ADHC center shall maintain a sign in and out log documenting the provision of services to participants.
2. Documentation shall include:
- a. The date the service was provided;
 - b. The duration of the service;
 - c. The arrival and departure time of the participant;
 - d. A description of the service provided; and
 - e. The title, name, and signature of the staff who provided the service.

(10) Goods and services shall:

- (a) Be individualized;
- (b) Meet identified needs required by the participant's person-centered service plan that are necessary to ensure the health, welfare, and safety of the participant;
- (c) Be items that are utilized to reduce the need for personal care or to enhance independence within the participant's home or community;
- (d) Not include experimental goods or services;
- (e) Not include chemical or physical restraints; and
- (f) Not be covered unless prior authorized by the department.

(11) A home delivered meal shall:

(a) Meet at least one-third (1/3) of the recommended daily allowance per meal and meet the requirements of the current version of the Dietary Guidelines for Americans published by United States Department of Agriculture and the United States Department of Health and Human Services;

(b) Be provided to a participant who is unable to prepare his or her own meals and for whom there are no other persons available to do so including natural supports;

(c) Be furnished in accordance with menus that are approved in writing by a licensed dietitian;

(d) Take into consideration the participant's medical restrictions; religious, cultural, and ethnic background; and dietary preferences;

(e) Be individually packaged heated meals;

(f) Be provided for inclement weather, holidays, or emergencies if prior approval is provided by the department and if the meals:

1. Are individually packaged if not heated;

2. Are shelf stable; or

3. Have components separately packaged if the components are clearly marked as components of a single meal; and

(g) Not:

1. Supplement or replace meal preparation activities that occur during the provision of attendant care services or any other similar service;

2. Supplement or replace the purchase of food or groceries;

3. Include bulk ingredients, liquids, and other food used to prepare meals independently or with assistance;

4. Be provided while the participant is hospitalized, residing in an institutional setting, or while in attendance at an ADHC center; or

5. Duplicate a service provided through other programs operated by any governmental agency.

(12)(a) Home and community support services shall consist of:

1. General household activities including;

a. Cleaning;

b. Cooking; or

c. Chores;

2. Personal care services including assistance with:

a. Bathing;

b. Grooming;

c. Dressing;

d. Eating;

e. Toileting;

f. Transferring;

g. Assistance with self-administration of medication; or

h. Ambulation; or

3. Transporting a participant to a needed place as specified in the participant's person-centered service plan including:

- a. A grocery;
- b. A pharmacy; or
- c. An appointment.

(b)1. An individual transporting a participant shall have a valid driver's license.

2. A minimum of current liability insurance shall be required for a vehicle used to transport a participant.

(13) Non-specialized respite care shall be provided:

- (a) To a participant who has care needs beyond normal baby-sitting or normal care sitting; and
- (b) In relief of a non-paid primary caregiver.

(14)(a) PDS coordination services shall include service advisory and management of funds.

(b) The financial management service provider shall:

1. Perform, on behalf of the participant, the employer responsibilities of payroll processing, which shall include:

- a. Issuing paychecks;
- b. Withholding federal, state, and local tax and making tax payments to the appropriate tax authorities; and
- c. Issuing W-2 forms;

2. Be responsible for performing all fiscal accounting procedures at least every thirty (30) days including issuing expenditure reports to:

- a. The participant, the participant's guardian, or the participant's legal representative;
- b. The participant's case manager; and
- c. Upon request, the department;

3. Maintain a separate account for each participant while continually tracking and reporting funds, disbursements, and the balance of the participant's prior authorizations; and

4. Process and pay invoices for:

- a. PDS goods and services approved in the person-centered service plan; and
- b. Environmental or minor home adaptations in the person-centered service plan.

Section 6. Miscellaneous Participant-Directed Services Requirements. (1) A PDS provider shall:

(a) Be selected by the participant;

(b) Be at least eighteen (18) years of age;

(c) Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a U.S. citizen;

(d) Be able to communicate effectively with the participant, representative, participant's guardian, or family of the participant;

(e) Be able to understand and carry out instructions;

(f) Be able to keep records as required by the participant;

(g) Comply with the requirements for background and related checks established in Section 2(3)(j) of this administrative regulation;

(h) Not be a PDS provider excluded from providing services in accordance with Section 2(3)(k) of this administrative regulation;

(i)1. Prior to the beginning of employment, complete training on the:

- a. Reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.030; and
- b. Needs of the participant; and

2. Receive DAIL attendant care training initially and then annually thereafter;

(j)1. Obtain first aid certification within six (6) months of providing PDS services; and

2. Maintain first aid certification for the duration of being a PDS provider;

- (k)1. Except as established in subparagraph 2 of this paragraph:
 - a. Obtain cardiopulmonary resuscitation (CPR) certification by a nationally accredited entity within six (6) months of employment; and
 - b. Maintain CPR certification for the duration of being a PDS provider; or
- 2. If the participant to whom a PDS provider provides services has a signed Do Not Resuscitate order, not be required to meet the requirements established in subparagraph 1 of this paragraph;
- (l) Comply with the TB risk assessment and test requirements established in Section 2(3)(h)5. of this administrative regulation;
- (m) Maintain and submit timesheets:
 - 1. Signed by the:
 - a. Participant or representative; and
 - b. Provider; and
 - 2. Documenting:
 - a. Hours worked;
 - b. The provision of a service including:
 - (i) A full description of the service provided; and
 - (ii) Any concerns or issues, if existing, regarding the general well-being of the participant; and
 - c. The participant's choice of daily activities and services; and
- (n) Submit a completed Kentucky Consumer Directed Options/Participant Directed Services Employee/Provider Contract to the service advisor.
- (2)(a) A participant may designate a representative to act on the participant's behalf.
- (b) A representative shall:
 - 1. Submit to all of the background and related checks established in Section 2(3)(j) of this administrative regulation;
 - 2. Be at least eighteen (18) years of age;
 - 3. Be chosen by the participant, except as established in paragraph (c) of this subsection, to manage and direct all related aspects of the participant's PDS; and
 - 4. Not be a PDS representative if found in violation of the provisions established in subsection (1)(h) of this section.
- (c) A representative shall be chosen for a participant if a condition established in this paragraph exists. If the participant:
 - 1. Is under eighteen (18) years of age, a family member of the participant shall appoint a representative for the participant;
 - 2. Has a guardian or legal representative, the participant's guardian or legal representative shall appoint a representative for the participant; or
 - 3. Has failed to adhere to the terms of a participant corrective action plan and chooses to continue receiving PDS, the participant's person-centered team shall present a list of multiple potential representatives to the participant from which the participant shall choose a representative.
- (d) A participant's choice of representative shall be made via a MAP-2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS), which the participant shall submit to the participant's service advisor.
- (3) A participant may voluntarily terminate PDS by completing a MAP-2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS) and submitting it to the participant's service advisor.
- (4) The department shall immediately terminate a participant from receiving PDS if:
 - (a) Imminent danger to the participant's health, safety, or welfare exists; or
 - (b) The participant's person-centered service plan indicates he or she requires more hours of service than the program can provide, which may jeopardize the participant's safety and welfare due to being left alone without a caregiver present.

- (5) A service advisor:
 - (a) Providing PDS coordination shall:
 - 1. Meet the case manager requirements established in Section 8(1) and (2) of this administrative regulation; and
 - 2. Within seven (7) days of receiving a referral regarding a participant from an independent assessor, schedule a face-to-face visit with the participant, the participant's guardian, or the participant's legal representative;
 - (b) Shall work with the participant or participant's legal representative to develop a participant corrective action plan:
 - 1. If the participant, participant's legal representative, or PDS employee has exhibited abusive, intimidating, or threatening behavior; or
 - 2. Pursuant to Section 8(7)(d) of this administrative regulation;
 - (c) For a participant with a participant corrective action plan:
 - 1. Shall monitor the progress of the participant corrective action plan; and
 - 2.a. Shall determine that the participant corrective action plan has been satisfied and continue with PDS;
 - b. May assist or direct the participant in appointing a representative pursuant to subsection (2)(c) of this section; or
 - c. Shall proceed with involuntary termination of PDS if the participant or legal representative is unable or unwilling to comply with the participant corrective action plan;
 - (d) If proceeding with involuntary termination, shall:
 - 1. Notify the independent assessor in writing of termination of PDS within thirty (30) days;
 - 2. Provide the participant or participant's legal representative with written information regarding the traditional waiver program and traditional waiver providers;
 - 3. Provide the participant or participant's legal representative with information regarding the right to appeal the PDS denial in accordance with 907 KAR 1:563;
 - 4. Complete and submit to the department a MAP-2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS) terminating the participant from PDS; and
 - 5. Document the:
 - a. Reason for the termination;
 - b. Actions taken to assist the participant with the participant corrective action plan; and
 - c. Outcomes; and
 - (e) Shall conduct at least one (1) in person visit with:
 - 1. The participant each month at the:
 - a. Participant's residence; or
 - b. ADHC center if the participant receives services at an ADHC center; and
 - 2. The participant's representative each three (3) months if designated by the participant.
- (6) Except as provided in subsection (4) or (5) of this section regarding a participant's termination from PDS, the participant's service advisor shall:
 - (a) Notify the independent assessor and service provider of potential termination;
 - (b) Assist the participant in developing a participant corrective action plan;
 - (c) Allow at least thirty (30) but no more than ninety (90) days for the participant to resolve the issue, develop and implement a prevention plan, or designate a PDS representative;
 - (d) Complete and submit to the department a MAP-2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS) terminating the participant from receiving PDS if the participant fails to meet the requirements established in paragraph (c) of this subsection; and
 - (e) Assist the participant in transitioning back to traditional HCB services by providing a current

list of traditional HCB service providers.

(7) A personal services agency shall:

- (a) Meet the requirements established in 906 KAR 1:180; and
- (b) Comply with the requirements of this section.

(8) An immediate family member, guardian, or legally responsible individual may provide a PDS upon written approval from the department if:

- (a) The individual submits to the department a completed PDS Request Form for Immediate Family Member, Guardian, or Legally Responsible Individual as a Paid Service Provider;
- (b) The individual has unique abilities necessary to meet the needs of the participant;
- (c) The individual has obtained education, job experience, volunteerism, or training beyond the direct care of the participant;
- (d) The services being provided are not natural supports;
- (e) The individual enables the participant to be integrated in the community; and
- (f) 1. The nearest provider is more than thirty (30) miles from the participant's residence; or
2. A qualified provider cannot:
 - a. Provide the necessary services according to the person-centered service plan; or
 - b. Accommodate the participant's schedule.

(9) A service advisor through PDS coordination shall:

- (a) Advise a participant regarding any aspect of PDS or blended services and facilitate access to services;
- (b) Provide information for accessing assistance twenty-four (24) hours per day, seven (7) days per week;
- (c) Comply with all applicable federal and state laws and requirements;
- (d) Continually monitor a participant's health, safety, and welfare and provide information on how to access resources;
- (e) Request a:
 - 1. Copy of the participant's current person-centered service plan; or
 - 2. Reassessment through the independent assessor; and
- (f) Conduct at least one (1) face-to-face visit:
 - 1. With the participant monthly;
 - 2. With the participant and the participant's representative, if the participant has a representative, at least once every three (3) months; and
 - 3. At the participant's residence at least once every three (3) months.

(10) A participant shall be responsible for all employer-related expenses and responsibilities.

(11) A PDS provider shall not provide more than forty (40) hours of PDS in a calendar week (Sunday through Saturday).

Section 7. Person-centered Service Plan Requirements. (1) A person-centered service plan shall:

- (a) Be established for each participant;
- (b) Be developed by:
 - 1. The participant, the participant's guardian, or the participant's legal representative;
 - 2. The participant's case manager or service advisor;
 - 3. The participant's person-centered team; and
 - 4. Any other individual chosen by the participant if the participant chooses any other individual to participate in developing the person-centered service plan;
- (c) Use a process that:
 - 1. Provides the necessary information and support to empower the participant, the participant's guardian, or participant's legal representative to direct the planning process in a way that empow-

ers the participant to have the freedom and support to control the participant's schedules and activities without coercion or restraint;

2. Is timely and occurs at times and locations convenient for the participant;

3. Reflects cultural considerations of the participant;

4. Provides information:

a. Using plain language in accordance with 42 C.F.R. 435.905(b); and

b. In a way that is accessible to an individual with a disability or who has limited English proficiency;

5. Offers an informed choice;

6. Includes a method for the participant to request updates to the person-centered service plan as needed;

7. Enables all parties to understand how the participant:

a. Learns;

b. Makes decisions; and

c. Chooses to live and work in the participant's community;

8. Discovers the participant's needs, likes, and dislikes; and

9. Empowers the participant's person-centered team to create a person-centered service plan that:

a. Is based on the participant's:

(i) Assessed clinical and support needs;

(ii) Strengths;

(iii) Preferences; and

(iv) Ideas;

b. Encourages and supports the participant's:

(i) Rehabilitative needs;

(ii) Habilitative needs; and

(iii) Long term satisfaction;

c. Is based on reasonable costs given the participant's support needs;

d. Includes:

(i) The participant's goals;

(ii) The participant's desired outcomes; and

(iii) Matters important to the participant;

e. Includes a range of supports including funded, community, and natural supports that shall assist the participant in achieving identified goals;

f. Includes:

(i) Information necessary to support the participant during times of crisis; and

(ii) Risk factors and measures in place to prevent crises from occurring;

g. Assists the participant in making informed choices by facilitating knowledge of and access to services and supports;

h. Records the alternative home and community-based settings that were considered by the participant;

i. Reflects that the setting in which the participant resides was chosen by the participant;

j. Is understandable to the participant and to the individuals who are important in supporting the participant;

k. Identifies the individual or entity responsible for monitoring the person-centered service plan;

l. Is finalized and agreed to with the informed consent of the participant or participant's representative in writing with signatures by each individual who will be involved in implementing the person-centered service plan;

m. Shall be distributed to the individual and other people involved in implementing the person-

centered service plan;

n. Includes those services that the individual elects to self-direct; and

o. Prevents the provision of unnecessary or inappropriate services and supports; and

(d) Include in all settings the ability for the participant to:

1. Have access to make private phone calls, texts, or emails at the participant's preference or convenience; and

2.a. Choose when and what to eat;

b. Have access to food at any time;

c. Choose with whom to eat or whether to eat alone; and

d. Choose appropriate clothing according to the:

(i) Participant's preference;

(ii) Weather; and

(iii) Activities to be performed.

(2) If a participant's person-centered service plan includes ADHC services, the ADHC services plan of treatment shall be addressed in the person-centered service plan.

(3)(a) A participant's person-centered service plan shall be:

1. Entered into the MWMA by the participant's case manager or service advisor; and

2. Updated in the MWMA by the participant's case manager or service advisor.

(b) A participant or participant's authorized representative shall complete and upload into the MWMA a MAP - 116 Service Plan – Participant Authorization prior to or at the time the person-centered service plan is uploaded into the MWMA.

Section 8. Case Management Requirements. (1) A case manager shall:

(a) Have:

1. A bachelor's degree in a health or human services field from an accredited college or university; and

2.a. At least one (1) year of experience in a health or human services field; or

b. The educational or experiential equivalent in the field of aging or disabilities; or

(b) Be a registered nurse who has:

1. At least two (2) years of experience as a professional nurse in the field of aging or disabilities; or

2. A master's degree in a health or human services field from an accredited college or university.

(2) A case manager shall be supervised by a case management supervisor who:

(a) Has at least four (4) years of experience as a case manager in the field of aging or disabilities; and

(b) Meets the requirements established in subsection (1) of this section.

(3) A case manager shall meet with a participant, the participant's guardian, or the participant's legal representative within seven (7) days of receiving a referral from an independent assessor regarding the participant.

(4) A case manager shall:

(a) Communicate in a way that ensures the best interest of the participant;

(b) Be able to identify and meet the needs of the participant;

(c) 1. Be competent in the participant's language either through personal knowledge of the language or through interpretation; and

2. Demonstrate a heightened awareness of the unique way in which the participant interacts with the world around the participant;

(d) Ensure that:

1. The participant is educated in a way that addresses the participant's:

- a. Need for knowledge of the case management process;
- b. Personal rights; and
- c. Risks and responsibilities as well as awareness of available services; and
- 2. All individuals involved in implementing the participant's person-centered service plan are informed of changes in the scope of work related to the person-centered service plan as applicable;
- (e) Have a code of ethics to guide the case manager in providing case management that shall address:
 - 1. Advocating for standards that promote outcomes of quality;
 - 2. Ensuring that no harm is done;
 - 3. Respecting the rights of others to make their own decisions;
 - 4. Treating others fairly; and
 - 5. Being faithful and following through on promises and commitments;
- (f) 1. Lead the person-centered service planning team; and
 - 2. Take charge of coordinating services through team meetings with representatives of all agencies involved in implementing a participant's person-centered service plan;
- (g) 1. Include the participant's participation, guardian's participation, or legal representative's participation in the case management process; and
 - 2. Make the participant's preferences and participation in decision making a priority;
- (h) Document:
 - 1. A participant's interactions and communications with other agencies involved in implementing the participant's person-centered service plan; and
 - 2. Personal observations;
- (i) Advocate for a participant with service providers to ensure that services are delivered as established in the participant's person-centered service plan;
- (j) Be accountable to:
 - 1. A participant to whom the case manager provides case management in ensuring that the participant's needs are met;
 - 2. A participant's person-centered team and provide leadership to the team and follow through on commitments made; and
 - 3. The case manager's employer by following the employer's policies and procedures;
- (k) Stay current regarding the practice of case management and case management research;
- (l) Assess the quality of services, safety of services, and cost effectiveness of services being provided to a participant in order to ensure that implementation of the participant's person-centered service plan is successful and done so in a way that is efficient regarding the participant's financial assets and benefits;
- (m) Accurately reflect in the MWMA if a participant is:
 - 1. Terminated from the HCB waiver program;
 - 2. Admitted to a hospital;
 - 3. Admitted to a skilled nursing facility;
 - 4. Transferred to another Medicaid 1915(c) home and community based waiver service program; or
 - 5. Relocated to a different address; and
- (n) Provide information about participant-directed services to the participant, participant's guardian, or participant's legal representative:
 - 1. At the time the initial person-centered service plan is developed; and
 - 2. At least annually thereafter and upon inquiry from the participant, participant's guardian, or participant's legal representative.
- (5)(a) Case management for any individual who begins receiving HCB waiver services shall be conflict free except as allowed in paragraph (b) of this subsection.

(b)1. Conflict free case management shall be a scenario in which a provider including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider who renders case management to a participant shall not also provide another 1915(c) home and community based waiver service to that same participant unless the provider is the only willing and qualified HCB waiver provider within thirty (30) miles of the participant's residence.

2. An exemption to the conflict free case management requirement shall be granted if:

a. A participant requests the exemption;

b. The participant's case manager provides documentation of evidence to the department that there is a lack of a qualified case manager within thirty (30) miles of the participant's residence;

c. The participant or participant's representative and case manager signs a completed MAP 531 Conflict-Free Case Management Exemption; and

d. The participant, participant's representative, or case manager uploads the completed MAP 531 Conflict-Free Case Management Exemption into the MWMA.

3. If a case management service is approved to be provided despite not being conflict free, the case management provider shall document conflict of interest protections, separating case management and service provision functions within the provider entity and demonstrate that the participant is provided with a clear and accessible alternative dispute resolution process.

4. An exemption to the conflict free case management requirement shall be requested upon reassessment or at least annually.

(c) A participant who receives HCB waiver services shall transition to conflict free case management when the participant's next level of care determination occurs.

(d) During the transition to conflict free case management, any case manager providing case management to a participant shall educate the participant and members of the participant's person-centered team of the conflict free case management requirement in order to prepare the participant to decide, if necessary, to change the participant's:

1. Case manager; or

2. Provider of non-case management HCB waiver services.

(e) If a participant chooses a new case manager in order to comply with the conflict free case management requirement, the new case manager and the participant's assessment team shall be responsible for:

1. Developing the material necessary for the participant's next level of care determination;

2. Submitting the material associated with the participant's next level of care determination to the MWMA;

3. Developing the participant's next person-centered service plan; and

4. Submitting the participant's next person-centered service plan to the MWMA.

(6) Case management shall involve:

(a) A constant recognition of what is and is not working regarding a participant; and

(b) Changing what is not working.

(7) A case manager shall:

(a) Arrange for a service but not provide a service directly;

(b) Contact the participant at least monthly by telephone or through a face-to-face visit with a minimum of one (1) face-to-face visit between the case manager and the participant:

1. Every other month in:

a. An adult day health care center; or

b. The participant's residence; and

2. At least three (3) times a calendar year in the participant's residence;

(c) Ensure that services are provided in accordance with the participant's person-centered service plan;

(d) Issue a participant corrective action plan if:

1. The participant does not comply with the person-centered service plan;
 2. The participant, a family member of the participant, an employee of the participant, the participant's guardian, or a legal representative of the participant threatens, intimidates, or consistently refuses services from any HCB waiver provider;
 3. Imminent threat of harm to the participant's health, safety, or welfare exists;
 4. The participant, a family member of the participant, an employee of the participant, the participant's guardian, or a legal representative of the participant interferes with or denies the provision of an assessment, case management, or service advisory; or
 5. If the PDS provider does not comply with the PDS provider requirements established in Section 6(1) of this administrative regulation; and
- (e) Issue a recommendation to the department for termination from HCB waiver services or PDS if a participant corrective action plan cannot be agreed upon or fulfilled by the participant, participant's guardian, or participant's legal representative.

Section 9. Critical Incident Reporting. (1)(a) An event that potentially or actually impacts the health, safety, or welfare of the participant shall be a critical incident.

(b) A critical incident may include:

1. Death;
2. Alleged or suspected abuse, neglect, or exploitation;
3. Homicidal or suicidal ideation;
4. Missing person;
5. A medication error resulting in consultation or intervention of a licensed medical professional;
6. An event involving police or emergency response personnel intervention; or
7. Other action or event that may result in harm to the participant.

(2)(a) If a critical incident occurs, the individual who witnessed the critical incident or discovered the critical incident shall immediately act to ensure the health, safety, and welfare of the at-risk participant.

(b) If the critical incident:

1. Requires reporting of abuse, neglect, or exploitation, the critical incident shall be immediately reported via the MWMA by the individual who witnessed or discovered the critical incident; or
2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported by the individual who witnessed or discovered the critical incident via the MWMA within eight (8) hours of discovery.

(c) The HCB waiver provider shall:

1. Conduct an immediate investigation and involve the participant's case manager in the investigation; and
2. Prepare a report of the investigation, which shall be recorded in the MWMA and shall include:
 - a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;
 - b. Details of the critical incident; and
 - c. Relevant participant information including:
 - (i) A listing of recent medical concerns;
 - (ii) An analysis of causal factors; and
 - (iii) Recommendations for preventing future occurrences.
- (d) The participant's case manager shall follow up to ensure that the participant's health, safety, and welfare are not jeopardized.

(3) An HCB provider shall report a medication error by making an entry into the MWMA.

Section 10. Involuntary Termination of HCB Waiver Services. (1) If the department involuntarily terminates a participant's participation in the HCB waiver program, the department shall:

(a) Notify in writing of the decision to terminate services the:

1. Participant's independent assessor;
2. Participant, participant's guardian, or participant's legal representative;
3. Participant's case manager; and
4. Participant's HCB waiver service providers; and

(b) Inform the participant, participant's guardian, or participant's legal representative of the right to appeal the department's decision to terminate HCB waiver services.

(2)(a) If an HCB waiver provider involuntarily terminates providing HCB waiver services to a participant, the HCB waiver provider shall:

1. At least thirty (30) days prior to the effective date of the termination:

a. Simultaneously notify in writing the:

- (i) Participant, participant's guardian, or participant's legal representative;
- (ii) Participant's case manager;
- (iii) The participant's independent assessor; and
- (iv) Department;

2. Document the termination in the MWMA; and

3. In conjunction with the participant's case manager:

a. Provide the participant, participant's guardian, or participant's legal representative with the name, address, and telephone number of each HCB waiver provider in Kentucky;

b. Provide assistance to the participant, participant's guardian, or participant's legal representative in contacting another HCB waiver provider; and

c. Provide a copy of pertinent information to the participant, participant's guardian, or participant's legal representative.

(b) The notice referenced in paragraph (a) of this subsection shall include:

1. A statement of the intended action;

2. The basis for the intended action;

3. The authority by which the intended action is taken; and

4. The participant's right to appeal the intended action through the provider's appeal or grievance process.

Section 11. Use of Electronic Signatures. The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

Section 12. Applicability and Transition to Version 2. (1) The provisions and requirements established in this administrative regulation shall not apply to individuals receiving HCB waiver services version 1 pursuant to 907 KAR 1:160.

(2) A participant receiving services pursuant to 907 KAR 1:160 shall transition to receiving services pursuant to this administrative regulation upon the participant's next level-of-care determination if the determination confirms that the individual is eligible for HCB waiver services version 2.

Section 13. Appeal Rights. An appeal of a department determination regarding NF level of care or services to a participant shall be in accordance with 907 KAR 1:563.

Section 14. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP – 115 Application Intake – Participant Authorization", May 2015;

(b) "MAP – 116 Service Plan – Participant Authorization", May 2015;

- (c) "MAP – 531 Conflict-Free Case Management Exemption", May 2015;
 - (d) "PDS Request Form for Immediate Family Member, Guardian, or Legally Responsible Individual as a Paid Service Provider", August 2015;
 - (e) "MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form", June 2015;
 - (f) "MAP-2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS)", June 2015;
 - (g) "Kentucky Consumer Directed Options/Participant Directed Services Employee/Provider Contract", June 2015; and
 - (h) "Kentucky Home Assessment Tool (K-HAT)", July 1, 2015.
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- (a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or
 - (b) Online at the department's Web site at: <http://www.chfs.ky.gov/dms/incorporated.htm>. (42 Ky.R. 1671; 2389; 2489; eff. 4-1-2016; TAm eff. 3-20-2020.)